FINANCING HEALTHCARE ORGANIZATIONS IN UZBEKISTAN

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ABSTRACT

This article aims to analyze the financing of healthcare organizations in Uzbekistan. The process of providing financial support for the healthcare system involves evaluating the amount and sources of necessary financial resources, organizing and choosing financing methods, promoting efficiency, maintaining control over the timeliness and legality of operations at all stages, and managing cash flow. The effective distribution of resources needed to raise the standard and accessibility of healthcare is a serious issue. Improving management techniques and procedures for weighing pros and cons of various resource distribution strategies and defending the selection of the optimal option—which takes into consideration social, political, technological, economic, and other aspects that necessitate research problem solving—are necessary for its resolution.

Key words: *financing, healthcare, organizations, resources, healthcare organizations.*

АННОТАЦИЯ

Целью данной статьи является анализ финансирования организаций здравоохранения в Узбекистане. Процесс финансового обеспечения системы здравоохранения предполагает оценку объема и источников необходимых финансовых ресурсов, организацию и выбор методов финансирования, повышение эффективности, обеспечение контроля за своевременностью и законностью операций на всех этапах, управление денежными потоками. Эффективное распределение ресурсов, необходимых для повышения уровня и доступности здравоохранения, является серьезной проблемой. Для ее решения необходимо совершенствование методов управления и процедур взвешивания плюсов и минусов различных стратегий распределения ресурсов и отстаивания выбора оптимального варианта, учитывающего социальные, политические, технологические, экономические и другие аспекты, вызывающие необходимость решения исследовательской задачи.

Ключевые слова: *финансирование, здравоохранение, организации, ресурсы, организации здравоохранения.*

ANNOTATSIYA

Ushbu maqolaning maqsadi O'zbekistondagi sog'liqni saqlash tashkilotlarini moliyalashtirishni tahlil qilishdir. Sog'liqni saqlash tizimini moliyaviy qo'llab-quvvatlash jarayoni zarur moliyaviy resurslarning hajmi va manbalarini baholash, moliyalashtirish usullarini tashkil etish va tanlash, samaradorlikni oshirish, barcha bosqichlarda operatsiyalarning o'z vaqtida va qonuniyligi ustidan nazoratni ta'minlash, pul oqimlarini boshqarishni o'z ichiga oladi. Tibbiyot sifati va undan foydalanish imkoniyatini oshirish uchun zarur resurslarni samarali taqsimlash asosiy muammo hisoblanadi. Uni hal qilish uchun turli xil resurslarni taqsimlash strategiyalarining ijobiy va salbiy tomonlarini ko'rib chiqish va hal qilishni talab qiladigan ijtimoiy, siyosiy, texnologik, iqtisodiy va boshqa jihatlarni hisobga olgan holda optimal variantni tanlashni targ'ib qilish bo'yicha boshqaruv usullari va tartiblarini takomillashtirish zarur. tadqiqot muammosi.

Kalit so'zlar: *moliyalashtirish, sog'liqni saqlash, tashkilotlar, resurslar, sog'liqni saqlash tashkilotlari.*

Introduction

According to research by international experts, global GDP annually loses up to 15 percent of its volume due to premature mortality and morbidity of the population. At the same time, according to statistics, about 17 million people die annually from chronic diseases, the development of which can be prevented, and another 8 million from infectious diseases. Taken together, premature mortality results in 43 days of life lost per resident each year, and the presence of chronic diseases reduces productivity by an average of 5 percent. In many countries, it is understood that the state is not always able to increase the budget funds allocated for health care to the required extent. This is due not only to the emergence of new expensive technologies and drugs, but also to the growing demands of patients who have no idea about the actual cost of medical services, the growing proportion of elderly people with chronic diseases, and the lack of awareness among many citizens of the need to lead a healthy lifestyle. According to the WHO, global health spending has doubled over the past two decades, reaching US$8.5 trillion, or 9.8 percent of global GDP. Despite this, about two billion people in the world face catastrophic medical costs.

Research methods

The methodology used authors is presented as all-round scientific methods of research - dialectical, systematic, sociological, as well as scientific methods - legal comparative, historical, structural, functional, normative, logical, technical and linguistic. Specifically, the author group will conduct statistical description analysis, correlation analysis to eliminate capital market between foreign countries. This basic

analysis step helps to check the appropriateness of the sample before performing regression analysis to ensure the reliability of quantitative research results.

Body

Healthcare is a field of activity whose tasks include providing affordable medical care to the population, maintaining and improving the level of health, in addition, it is an unusually resource-intensive industry that requires a lot of financial, material, labor and other resources.

Financial resources of healthcare institutions are the totality of funds under the operational management of this institution. They are the result of the interaction of receipts and expenses, distribution of funds, their accumulation and use. The following sources are used to finance healthcare institutions: budget (federal and territorial); compulsory health insurance funds; funds received from performing work (services), holding events on a paid basis; income from business and other activities; voluntary contributions; other cash receipts.

Unfortunately, there is currently a wide range of approaches to the use of funds from medical institutions - from severe restrictions to waste and abuse.

Financial resources of budgetary institutions are the totality of funds under the operational management of budgetary institutions. They are the result of the interaction of receipts and expenses, distribution of funds, their accumulation and use.

Currently, the following sources are used to finance healthcare institutions:

- Budget funds allocated to health care institutions based on established standards.

Budgetary financing standards act as a price (tariff) for those works (services) provided by the state to the consumer.

- Resources of compulsory health insurance funds, funds of medical insurance organizations.

- Funds of state, private and public organizations, citizens, received from performing work (services), carrying out events on a paid basis in accordance with the conclusion of contracts with legal entities and orders of the population. For example, this may include the receipt of funds for the provision of above-standard services in the field of medical care for citizens.

- Income from business and other types of activities (receipts from the sale of products of own production (for example, medicines, medical supplies, etc.), income from the rental of fixed assets and property of a healthcare institution; acquisition of securities and receipt of dividends on them etc.). Services related to the business activities of healthcare institutions are determined by the legislative acts of Uzbekistan material assets transferred to a health care institution, coming from state enterprises and public organizations, charitable and other public foundations, individual citizens (including funds from guardians), etc.

- Other cash receipts (loans, leasing transactions, issue of securities, etc.).

Treatment and prevention institutions included in the list (Appendix No. 3 to the above decree) must provide:

a gradual and consistent transition from fully budgetary financing of its activities to functioning in conditions of self-financing of the volume of medical services provided, i.e., the introduction of paid medical services;

reliability and equal access for patients to receive timely and qualified medical care, regardless of the form of payment;

high quality and compliance with medical and sanitary standards of medical services provided to the population at all stages of service.

The transition of medical institutions to paid provision of medical services is carried out in accordance with the timing and volumes determined by the State Program for Reforming the Health Care System (Appendix No. 3 to the Decree of the President of the Republic of Uzbekistan dated November 10, 1998 No. UP-2107) and also based on the population's demand for additional (beyond those guaranteed by the state) types of medical care.

In health care institutions (health care institutions) of mixed financing, two forms of financing operate simultaneously - budget financing and self-financing. The basis for determining the volume of financial resources in both forms is the cost of expenses necessary to provide medical services to the patient in accordance with approved medical and economic standards for types of diseases and social groups of the population. The form of self-financing is developing with the transition and expansion of paid provision of medical services. The main sources of financial resources for mixed-finance treatment and prevention institutions are: budget funds, the volumes of which are determined in the prescribed manner depending on the number of patients treated and the population of the serviced territory.

The volumes of budgetary funds used by health care facilities are gradually decreasing as paid forms of servicing the population develop; funds of enterprises and organizations transferred to the accounts of medical institutions for the volume of preventive and medical services provided to employees of these enterprises and organizations and members of their families in accordance with concluded agreements; payment by patients (sponsors) for additional medical services (including medical nutrition) provided by medical institutions in excess of the state-guaranteed volumes of medical care to the population; sponsors' funds; other sources not prohibited by law.

At present, the procedure for planning health care costs that was in force before the advent of the health insurance system is partially preserved, and the financing of health care institutions is carried out on the basis of an estimate principle: each institution is approved by an estimate of expenses incurred from allocated funds.

Financial resources are planned and allocated to institutions according to the items of economic classification of budget expenditures.

According to the established procedure, the preparation of an individual estimate of a medical institution is carried out based on cost standards per unit of volume of work performed and indicators of the volume of work of each department: the average annual number of beds, the number of bed days, the average annual number of positions of medical and administrative personnel, the number of outpatient visits etc. For example, for outpatient care, expenses were planned according to the number of doctor visits in the clinic (approximately 12 visits per year), and for inpatient care - according to the average annual number of beds.

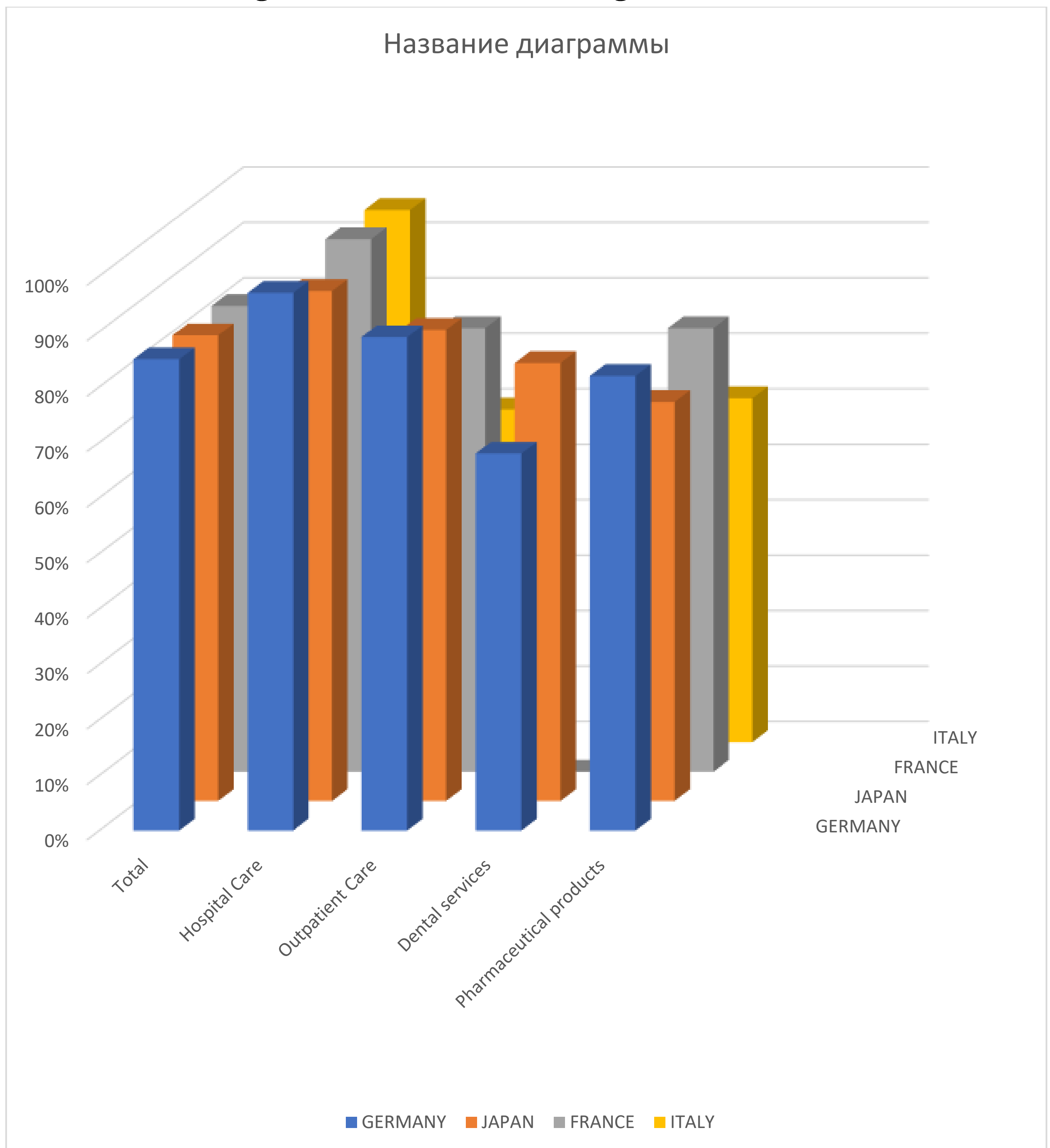
According to experts, investments in public health can significantly improve people's quality of life, protect against negative risks and lead to significant economic returns by increasing labor productivity. Research has shown that health contributes almost as much to income growth as education.

Today, the global health insurance market has reached US$2.09 trillion, and by 2030 this figure will be approximately US$2.93 trillion. In international practice, a distinction is made between compulsory and voluntary health insurance systems, where citizens, employers, the state can act as insurers, and a mixed insurance system is possible. The most common is a system in which the insurance premium is paid by citizens and employers in equal shares, and the state contributes funds for socially vulnerable segments of the population (children, pensioners, disabled people, etc.).

At the present stage in developed countries, compulsory health insurance protects people from unforeseen risks, since the system provides medical care to all segments of society, covering all or part of their expenses.

Analysis of health system financing shows that in member countries of the Organization for Economic Co-operation and Development, funds coming from government and non-government insurance contributions cover about three quarters of all health care costs. In Germany, Japan and France, this share exceeds 80 percent, while in Mexico and Brazil less than half of all health expenditures are spent (49 and 41 percent, respectively).

Coverage of healthcare costs through insurance funds



An aging population is also contributing to the growth of the insurance market, as the population aged 60 years and over is expected to increase from 1 billion in 2020 to 2 billion by 2050, according to WHO. Meanwhile, the number of people aged 80 and over will triple between 2020 and 2050 to reach 426 million.

One of the main advantages of the compulsory health insurance (CHI) system is its financial stability. Insurance premiums paid by employers and citizens go to finance medical services, as well as the development of healthcare in general. This allows medical institutions to provide quality services.

Current status and problems of healthcare financing in Uzbekistan

Today in Uzbekistan, health care financing is still carried out primarily from budget funds on an estimated basis, which does not correspond to international practice and leads to inefficient use of financial resources and chronic underfunding of the industry.

At the end of 2022, budget expenditures on health care amounted to 27.3 trillion soums (3.3 percent of GDP). Despite this, the World Bank, in its report "Review of Public Expenditures of Uzbekistan: Improving the Efficiency of Expenditures in Human Capital and Water Infrastructure", pointed out the following as the main challenges affecting the provision of quality medical services in Uzbekistan:

- low level of efficiency of spending on health care services;
- lack of adequate mechanisms for financing the activities of hospitals that stimulate their efficiency and effectiveness;
- withdrawal of a large share of income from households' pockets (over 60 percent of all expenditures) to finance health care, as well as official and unofficial payments to public health service providers;
- lack of access to health care among low-income populations.

In Uzbekistan, initial steps to reform the financing of the health care system began in 2018. At a video conference call held on November 9, 2018, the head of state noted the need for a phased introduction of the state health insurance system (one of the types of compulsory medical insurance) in the country starting in 2021, as well as the development of relevant laws and regulations based on the experience of South Korea, Singapore, Germany and other countries.

To implement these measures, a special State Health Insurance Fund has been created under the Ministry of Health of the Republic of Uzbekistan. In the "Development Strategy of New Uzbekistan for 2022–2026," the implementation date for compulsory medical insurance was postponed to July 1, 2023 for the city of Tashkent and December 1, 2023 for the rest of the country's regions. For this purpose, the State Health Insurance Fund allocated for the purchase of guaranteed medical packages: Tashkent - 1703.3 billion soums, Syrdarya region - 711.2 billion soums and Khorezm region - 3.6 billion soums.

At the same time, according to the Strategy "Uzbekistan - 2030", the deadline for the phased introduction of state health insurance for the city of Tashkent was postponed to January 1, 2024, and by Decree of the President of the Republic of Uzbekistan dated September 6, 2023 No. UP-156, the Minister of Health and the Executive Director of the State Health Insurance Fund were determined responsible for the full implementation of state health insurance by the end of 2026 throughout the republic.

In turn, the available information from the Ministry of Health on the work done and further steps to introduce state health insurance in Uzbekistan does not fully allow us to assess the effectiveness of the measures taken in this direction.

Recommendations for organizing compulsory medical insurance in Uzbekistan

To fully implement a modern healthcare financing model that meets the requirements of society, it is proposed to take the following measures:

Conduct a detailed analysis of the state of budgetary financing of healthcare, taking into account foreign experience (Germany, Israel, etc.), develop a mechanism for organizing compulsory medical insurance (compulsory health insurance), based on social responsibility and justice, taking into account the characteristics of the Uzbek economy and healthcare, where everyone a citizen, regardless of his socio-economic situation, will have the right to receive medical care.

Develop rules and conditions governing financial flows, schemes for the provision of medical care, and control over the quality of medical services provided. Create an electronic database containing complete information about the policyholder, diagnosis, medical history, etc. Prepare proposals for the components of the medical basket based on the cost of insurance premiums, which will include a guaranteed volume of medical care, taking into account medicines. At the same time, provide measures for the safety of the policyholder in the event of a decrease in income or a period of unemployment. For example, in Germany, when income decreases, medical care is provided at a lower price. At the same time, relatives who have no income (spouse, children under 18 years of age) can be insured free of charge under the same policy and enjoy the same benefits. The draft developed methodology (mechanism, rules, conditions, cost of the insurance policy) must be submitted for wide public discussion and an information campaign be conducted among the population about the advantages of this system and the rules for its use, as well as protection from financial risks associated with unexpected costs for medical treatment. It should be taken into account that this system must be based on the principles of compulsoriness, cover a wide segment of the population, and be fair, that is, contributions to health insurance must correspond to the income of the population in order to prevent the emergence of inequality in receiving medical care.

The ultimate goal of such a system is to ensure public health, increase productivity and improve the quality of life of the population, financial stabilization in the medical field - the tasks provided for by the Uzbekistan - 2030 Strategy, which was also emphasized by the President of the Republic of Uzbekistan during his speech at the 78th session of the General Assembly UN in September 2023.

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